AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name:_____ Birthdate: _____ Phone: _____ Soc Sec No: : _____

I hereby authorize release of information

FROM:

I hereby authorize release of information:

TO:
Prairie Sinus Ear & Allergy P.C.
3000 North 14th St. 3rd Floor Bismarck, ND 58503-0697

the following information from my medical records:

□ **All clinical records of care - medical, surgical, hospital, lab, imaging, Audiology, & Summary of Care**

□ **Entire clinical record - (medical, surgical, hospital, lab, imaging, audiologic)** □ **Last 2 years only of clinical record**

□Radiology Reports □ Operative Reports □ Audiology Records □Billing Records □ Other: Please specify: _____

SENSITIVE RECORDS PERTAINING TO MINORS or PSYCHIATRIC/MENTAL HEALTH, CHEMICAL DEPENDANCY and/or HIV/HIV RELATED ILLNESS WILL NOT BE RELEASED UNLESS SPECIFICALLY AUTHORIZED BELOW IN WRITING.

I specifically authorize the release of the following records:

□ Psychiatric/Psychological □ HIV □ Drug And/or Alcohol Dependency Signature:_____ Date: _____

□ Contraception/STD's (If ages 14-17) Signature:_____ Date: _____

The information is necessary for the following purpose: □ Diagnosis & Treatment □ Legal □ Insurance □ Billing □ Military

□ Personal: _____ □ Other: _____

This authorization shall remain in effect until the following date, event, or condition: _____

(If no date, event, or condition is specified, this authorization will expire in one year)

1. This authorization remains in effect until the above date, event, or condition, unless specifically revoked by written notice to the individual or organization. I understand that this authorization may be revoked at any time. Any information released prior to my written revocation of this authorization shall not be breach of confidentiality.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization.
3. I understand that I may inspect or request copies of any information disclosed under this authorization and that I am entitled to a copy of this authorization form once I have signed it.
4. I understand that if the individual or organization that receives the information is not a health care provider or health plan covered by federal privacy regulations the information described above may be redisclosed and no longer protected by these federal regulations.
5. A photocopy of this authorization is as effective as the original.
6. I understand that Prairie SEA Clinic will not receive payment in connection with the use or disclosure of my health information, unless specified here: _____. This does not apply to a reasonable fee for copying and mailing when releasing records directly to the patient. There is no charge if records are released to a physician, hospital, clinic, or other medical facility for continued care purposes. (See separate policy)

_____	_____	_____	_____
(Printed Name)	**(Signature)**	**(Relationship)**	**(MM/DD/YY)**

Photo ID checked by: Print Name_____ Initials ___
or
Signature verified by: Print Name_____ Initials ___

_____

□ **CHECK IF YOU ARE A LEGAL REPRESENTATIVE**
PLEASE STATE REASON PATIENT CANNOT SIGN: _____

□ CHECK IF APPLICABLE – NOTICE TO WHOMEVER DISCLOSURE IS MADE CONCERNING CHEMICAL DEPENDENCY RECORDS

AUTHORIZATION FOR RELEASE OF INFORMATION

This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal Regulations (42-CFR Part 2) prohibits you from making any further disclosure of it without the specified written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for release of information is NOT sufficient for this purpose.

3000 North 14th Street 3rd Floor Bismarck, N.D. 58503 Tel: (701) 805-8057 Fax: (701) 751-3143